

EXHIBIT D

1500

HEALTH INSURANCE CLAIM FORM

APPROVED BY NATIONAL UNIFORM CLAIM COMMITTEE 08/08

AETNA USHC
PO BOX 991106
EL PASO, TX 79906

<input type="checkbox"/> PICA 1. MEDICARE <input type="checkbox"/> MEDICAID <input type="checkbox"/> TRICARE <input type="checkbox"/> CHAMPVA <input type="checkbox"/> GROUP HEALTH PLAN <input type="checkbox"/> FECA <input checked="" type="checkbox"/> OTHER <input type="checkbox"/> (For Program in Item 4)		1a. INSURED'S I.D. NUMBER 0000000000	
2. PATIENT'S NAME (Last Name, First Name, Middle Initial) O'CONNOR, D.		4. INSURED'S NAME (Last Name, First Name, Middle Initial) O'CONNOR, D.	
3. PATIENT'S ADDRESS (No., Street) [REDACTED]		7. INSURED'S ADDRESS (No., Street) [REDACTED]	
CITY [REDACTED] STATE [REDACTED] ZIP CODE [REDACTED] TELEPHONE (Include Area Code) [REDACTED]		CITY [REDACTED] STATE [REDACTED] ZIP CODE [REDACTED] TELEPHONE (Include Area Code) [REDACTED]	
5. PATIENT RELATIONSHIP TO INSURED Self <input checked="" type="checkbox"/> Spouse <input type="checkbox"/> Child <input type="checkbox"/> Other <input type="checkbox"/>		8. PATIENT STATUS Single <input type="checkbox"/> Married <input type="checkbox"/> Other <input checked="" type="checkbox"/>	
9. OTHER INSURED'S NAME (Last Name, First Name, Middle Initial) O'CONNOR, D.		10. IS PATIENT'S CONDITION RELATED TO: a. EMPLOYMENT? (Current or Previous) YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
6. OTHER INSURED'S POLICY OR GROUP NUMBER [REDACTED]		b. AUTO ACCIDENT? <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO c. OTHER ACCIDENT? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO	
7. OTHER INSURED'S DATE OF BIRTH [REDACTED] SEX M <input type="checkbox"/> F <input checked="" type="checkbox"/>		11. INSURED'S POLICY GROUP OR FECA NUMBER [REDACTED]	
8. EMPLOYER'S NAME OR SCHOOL NAME [REDACTED]		a. INSURED'S DATE OF BIRTH [REDACTED] SEX M <input type="checkbox"/> F <input checked="" type="checkbox"/>	
9. INSURANCE PLAN NAME OR PROGRAM NAME PROCURA		b. EMPLOYER'S NAME OR SCHOOL NAME [REDACTED]	
10. IS THERE ANOTHER HEALTH BENEFIT PLAN? <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO If yes, return to and complete Item 9 and c.		c. INSURANCE PLAN NAME OR PROGRAM NAME AETNA USHC	
12. PATIENT'S OR AUTHORIZED PERSON'S SIGNATURE I authorize the release of any medical or other information necessary to process this claim. I also request payment of government benefits either to myself or to the party who accepts assignment below. SIGNED [Signature on File] DATE 04 08 2011		13. INSURED'S OR AUTHORIZED PERSON'S SIGNATURE I authorize payment of medical benefits to the undersigned physician or supplier for services described below. SIGNED [Signature on File]	
14. DATE OF CURRENT ILLNESS (First symptoms) OR INJURY (Accident OR PREGNANCY/CLMP) MM DD YY 04 08 11		15. IF PATIENT HAS HAD SAME OR SIMILAR ILLNESS, GIVE FIRST DATE MM DD YY [REDACTED]	
16. DATE PATIENT UNABLE TO WORK IN CURRENT OCCUPATION FROM MM DD YY TO MM DD YY [REDACTED]		17. HOSPITALIZATION DATES RELATED TO CURRENT SERVICES FROM MM DD YY TO MM DD YY [REDACTED]	
17. NAME OF REFERRING PROVIDER OR OTHER SOURCE [REDACTED]		18. OUTSIDE LAB? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO \$ CHARGES [REDACTED]	
19. RESERVED FOR LOCAL USE		20. MEDICARE REBILUMINATION CODE [REDACTED] ORIGINAL REF. NO. [REDACTED]	
21. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY (Relate Items 1, 2, 3 or 4 to Item 24E by Line) 1. 722.10 LUMBAR DISC DISPLACE 2. 724.2 LUMBAGO 3. 724.4 LUMBOSACRAL NEURITIS 4. 724.02 SPINAL STENOSIS LUMB		22. PRIOR AUTHORIZATION NUMBER [REDACTED]	
24. A. DATE(S) OF SERVICE FROM MM DD YY TO MM DD YY 04 08 11 04 08 11 B. PLACE OF SERVICE BKG 21 02 C. PROCEDURES, SERVICES, OR SUPPLIES (Explain Unusual Circumstances) CPT/HCPCS 63047 59 D. DIAGNOSIS POINTER 1234		F. \$ CHARGES 88423 00 G. DATE OF UTE 1 H. PAY BY DATE I. NO. QUAL J. RENDERING PROVIDER ID. # NPI	
1 04 08 11 04 08 11 21 02 63047 59 1234 88423 00 1 NPI		2 04 08 11 04 08 11 21 02 63048 50 1234 11513 00 1 NPI	
3 04 08 11 04 08 11 21 02 63090 59 1234 30123 00 1 NPI		4 04 08 11 04 08 11 21 02 22830 50 1234 38822 00 1 NPI	
5 04 08 11 04 08 11 21 02 22830 50 1234 38822 00 1 NPI		6 04 08 11 04 08 11 21 02 22851 50 1234 11360 00 1 NPI	
25. FEDERAL TAX I.D. NUMBER SSN EIN 27-4820460 [REDACTED]		26. PATIENT'S ACCOUNT NO. [REDACTED]	
27. ACCEPT ASSIGNMENT? <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO		28. TOTAL CHARGE \$ 257117.00	
29. AMOUNT PAID \$ 0.00		30. BALANCE DUE \$ 257117.00	
31. SIGNATURE OF PHYSICIAN OR SUPPLIER INCLUDING DEGREE(S) OR CREDENTIALS (I certify that the statements on the reverse apply to this bill and are made a part thereof.) JOHN CIFELLI, MD SIGNED [Signature] DATE 04 08 2011		32. SERVICE FACILITY LOCATION INFORMATION ST MARY'S HOSPITAL 350 BOULEVARD PASSAIC, NJ 07055 1609748000	
33. BILLING PROVIDER INFO & PH# 973 777 8278 NEUROLOGICAL SURGERY ASSOCIATES, PA 1054 CLIFTON AVENUE CLIFTON NJ 07015 1295760000		34. BILLING PROVIDER INFO & PH# 973 777 8278 NEUROLOGICAL SURGERY ASSOCIATES, PA 1054 CLIFTON AVENUE CLIFTON NJ 07015 1295760000	

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APPROVED OMB-0938-0098 FORM CMS-1500 (08)

CIF000004

1500

HEALTH INSURANCE CLAIM FORM

APPROVED BY NATIONAL UNIFORM CLAIM COMMITTEE 08/05

AETNA USHC
PO BOX 981108
EL PASO, TX 79998

<input type="checkbox"/> PICA 1. MEDICARE <input type="checkbox"/> MEDICAID <input type="checkbox"/> TRICARE <input type="checkbox"/> CHAMPVA <input type="checkbox"/> GROUP HEALTH PLAN <input type="checkbox"/> FICA <input type="checkbox"/> OTHER <input type="checkbox"/> (For Program in Item 1)		1a. INSURED'S ID. NUMBER [REDACTED]	
2. PATIENT'S NAME (Last Name, First Name, Middle Initial) [REDACTED]		3. PATIENT'S BIRTH DATE [REDACTED]	
4. INSURED'S NAME (Last Name, First Name, Middle Initial) [REDACTED]		5. INSURED'S ADDRESS (No., Street) [REDACTED]	
6. PATIENT'S ADDRESS (No., Street) [REDACTED]		7. INSURED'S ADDRESS (No., Street) [REDACTED]	
8. PATIENT RELATIONSHIP TO INSURED Self <input checked="" type="checkbox"/> Spouse <input type="checkbox"/> Child <input type="checkbox"/> Other <input type="checkbox"/>		9. PATIENT STATUS Single <input type="checkbox"/> Married <input type="checkbox"/> Other <input checked="" type="checkbox"/>	
10. IS PATIENT'S CONDITION RELATED TO: a. EMPLOYMENT? (Current or Previous) <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO b. AUTO ACCIDENT? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO c. OTHER ACCIDENT? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO		11. INSURED'S POLICY GROUP OR FICA NUMBER [REDACTED]	
12. PATIENT'S OR AUTHORIZED PERSON'S SIGNATURE I authorize this release of any medical or other information necessary to process this claim. I also request payment of government benefits either to myself or to the party who accepts assignment below. Signature on File. DATE 04 08 2011 SIGNED [REDACTED]		13. INSURED'S OR AUTHORIZED PERSON'S SIGNATURE I authorize payment of medical benefits to the undersigned physician or supplier to services described below. Signature on File SIGNED [REDACTED]	
14. DATE OF CURRENT ILLNESS (First symptom), OR INJURY (Accident) OR PREGNANCY (EMP) MM DD YY [REDACTED]		15. IF PATIENT HAS HAD SAME OR SIMILAR ILLNESS, GIVE FIRST DATE MM DD YY [REDACTED]	
16. DATES PATIENT UNABLE TO WORK IN CURRENT OCCUPATION FROM MM DD YY TO MM DD YY [REDACTED]		17. HOSPITALIZATION DATES RELATED TO CURRENT SERVICES FROM MM DD YY TO MM DD YY [REDACTED]	
18. OUTSIDE LAB? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO		19. CHARGES \$ [REDACTED]	
20. MEDICAID REBUBBING 8 CODE [REDACTED] ORIGINAL REF. NO. [REDACTED]		21. PRIOR AUTHORIZATION NUMBER [REDACTED]	
22. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY (Relate items 1, 2, 3 or 4 to Item 24b by Line) 1. 722 10 LUMBAR DISC DISPLACE 2. 724 2 LUMBAGO 3. 724 4 LUMBOSACRAL NEURITIS 4. 724 02 SPINAL STENOSIS LUMB		23. MEDICAL RECORDS [REDACTED]	
24. A. DATES OF SERVICE From MM DD YY To MM DD YY B. PLACE OF SERVICE C. EMG D. PROCEDURES, SERVICES, OR SUPPLIES (Specify Unusual Circumstances) E. DIAGNOSIS F. CHARGES G. DATES OF VISIT H. PHYSICIAN I. D. QUAL J. RENDERING PROVIDER ID. #		[REDACTED]	
25. FEDERAL TAX ID. NUMBER SSN EIN 27-4820480 [REDACTED]		26. PATIENT'S ACCOUNT NO. [REDACTED]	
27. SIGNATURE OF PHYSICIAN OR SUPPLIER INCLUDING DISC REF OR CREDENTIALS (I certify that the statements on the reverse apply to this bill and are made a part thereof.) JOHN CIFELLI, MD SIGNED DATE 04 08 2011		28. SERVICE FACILITY LOCATION INFORMATION ST. MARY'S HOSPITAL 360 BOULEVARD PASSAIC, NJ 07065 1-800-745-1234	
29. BILLING PROVIDER INFO & PH # (973) 777 9279 NEUROLOGICAL SURGERY ASSOCIATES, PA 1064 CLIFTON AVENUE CLIFTON NJ 07013		30. TOTAL CHARGE \$ 257117.00 31. AMOUNT PAID \$ 0.00 32. BALANCE DUE \$ 257117.00	

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APPROVED OMB-0938-0999 FORM CMS-1500 (06

CIF000005

1500

HEALTH INSURANCE CLAIM FORM

APPROVED BY NATIONAL UNIFORM CLAIM COMMITTEE 08/05

AETNA USHC
PO BOX 981108
EL PASO, TX 79998

1. MEDICARE <input type="checkbox"/> MEDICAID <input type="checkbox"/> TRICARE <input type="checkbox"/> CHAMPVA <input type="checkbox"/> GROUP HEALTH PLAN <input type="checkbox"/> FICA <input checked="" type="checkbox"/> OTHER <input type="checkbox"/> (ID)										1a. INSURED'S I.D. NUMBER (For Program in Item 1)																																																																					
2. PATIENT'S NAME (Last Name, First Name, Middle Initial) O. [REDACTED] D. [REDACTED]										3. PATIENT'S BIRTH DATE [REDACTED]										4. INSURED'S NAME (Last Name, First Name, Middle Initial) O. [REDACTED] D. [REDACTED]																																																											
5. PATIENT'S ADDRESS (No., Street) [REDACTED]										6. PATIENT RELATIONSHIP TO INSURED Self <input checked="" type="checkbox"/> Spouse <input type="checkbox"/> Child <input type="checkbox"/> Other <input type="checkbox"/>										7. INSURED'S ADDRESS (No., Street) [REDACTED]																																																											
CITY [REDACTED]										STATE [REDACTED]										CITY [REDACTED]										STATE [REDACTED]																																																	
ZIP CODE [REDACTED]										TELEPHONE (Include Area Code) [REDACTED]										ZIP CODE [REDACTED]										TELEPHONE (Include Area Code) [REDACTED]																																																	
8. OTHER INSURED'S NAME (Last Name, First Name, Middle Initial) O. [REDACTED] D. [REDACTED]										9. PATIENT'S CONDITION RELATED TO: a. EMPLOYMENT? (Current or Previous) YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>										10. INSURED'S POLICY OR FICA NUMBER [REDACTED]																																																											
11. OTHER INSURED'S POLICY OR GROUP NUMBER [REDACTED]										12. OTHER INSURED'S DATE OF BIRTH [REDACTED]										13. INSURED'S DATE OF BIRTH [REDACTED]										14. EMPLOYER'S NAME OR SCHOOL NAME [REDACTED]																																																	
15. EMPLOYER'S NAME OR SCHOOL NAME [REDACTED]										16. INSURANCE PLAN NAME OR PROGRAM NAME PROCURA										17. IS THERE ANOTHER HEALTH BENEFIT PLAN? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> If yes, return to and complete Item 9 a-d.																																																											
18. PATIENT'S OR AUTHORIZED PERSON'S SIGNATURE (I authorize the release of any medical or other information necessary to process this claim. I also request payment of government benefits either to myself or to the party who accepts assignment below.) SIGNED: [REDACTED] DATE: 04 08 2011										19. INSURED'S OR AUTHORIZED PERSON'S SIGNATURE (I authorize payment of medical benefits to the undersigned physician or supplier if services described below.) SIGNED: [REDACTED]																																																																					
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23. NAME OF REFERRING PROVIDER OR OTHER SOURCE [REDACTED]										24. HOSPITALIZATION DATES RELATED TO CURRENT SERVICES FROM MM DD YY TO MM DD YY [REDACTED]										25. OUTSIDE LAB? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> \$ CHARGES [REDACTED]																																																											
26. RESERVED FOR LOCAL USE										27. MEDICARE REBILITATION CODE [REDACTED]										28. PRIOR AUTHORIZATION NUMBER [REDACTED]																																																											
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37. FEDERAL TAX I.D. NUMBER 27-4820480										38. PATIENT'S ACCOUNT NO. [REDACTED]										39. ACCEPT ASSIGNMENT? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>										40. TOTAL CHARGE \$ 267117 00										41. AMOUNT PAID \$ 0 00										42. BALANCE DUE \$ 267117 00																													
43. SIGNATURE OF PHYSICIAN OR SUPPLIER INCLUDING DEGREE OR CREDENTIALS (I certify that the statements on the reverse apply to this bill and are made a part thereof.) JOHN CIFELLI, MD										44. SERVICE FACILITY LOCATION INFORMATION ST MARY'S HOSPITAL 350 BOULEVARD PASSAIC, NJ 07055										45. BILLING PROVIDER INFO & PHONE 973 777 8278 NEUROLOGICAL SURGERY ASSOCIATES, PA 1054 CLIFTON AVENUE CLIFTON, NJ 07013																																																											
SIGNED: [REDACTED] DATE: 04 08 2011										SIGNED: [REDACTED]										SIGNED: [REDACTED]																																																											

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APPROVED OMB-0938-0999 FORM CMS-1500 (08

CIF000006

1500

HEALTH INSURANCE CLAIM FORM

APPROVED BY NATIONAL UNIFORM CLAIM COMMITTEE 06/08

AETNA USHC
PO BOX 981108
EL PASO, TX 79998

<input type="checkbox"/> PICA 1. MEDICARE <input type="checkbox"/> MEDICAID <input type="checkbox"/> TRICARE <input type="checkbox"/> CHAMPVA <input type="checkbox"/> GROUP HEALTH PLAN <input type="checkbox"/> FICA (LINO) <input type="checkbox"/> OTHER <input type="checkbox"/> (ID)		1a. INSURED'S ID. NUMBER (For Program in Item 1)	
2. PATIENT'S NAME (Last Name, First Name, Middle Initial) O. [REDACTED] D. [REDACTED]		3. PATIENT'S BIRTH DATE M [REDACTED] D [REDACTED] Y [REDACTED]	
4. INSURED'S NAME (Last Name, First Name, Middle Initial) O. [REDACTED] D. [REDACTED]		5. PATIENT'S ADDRESS (No. Street) [REDACTED]	
6. PATIENT RELATIONSHIP TO INSURED Self <input checked="" type="checkbox"/> Spouse <input type="checkbox"/> Child <input type="checkbox"/> Other <input type="checkbox"/>		7. INSURED'S ADDRESS (No. Street) [REDACTED]	
8. PATIENT STATUS Single <input type="checkbox"/> Married <input type="checkbox"/> Other <input checked="" type="checkbox"/>		9. CITY [REDACTED]	
10. IS PATIENT'S CONDITION RELATED TO: a. EMPLOYMENT? (Current or Previous) YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		11. INSURED'S POLICY GROUP OR FICA NUMBER [REDACTED]	
b. AUTO ACCIDENT? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		12. INSURED'S DATE OF BIRTH M [REDACTED] D [REDACTED] Y [REDACTED]	
c. OTHER ACCIDENT? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13. EMPLOYER'S NAME OR SCHOOL NAME [REDACTED]	
14. INSURANCE PLAN NAME OR PROGRAM NAME PROCURA		14. IS THERE ANOTHER HEALTH BENEFIT PLAN? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> If yes, return to and complete Item 9 a-c.	
15. PATIENT'S OR AUTHORIZED PERSON'S SIGNATURE Signature on File SIGNED [REDACTED] DATE 04 08 2011		16. INSURED'S OR AUTHORIZED PERSON'S SIGNATURE Signature on File SIGNED [REDACTED]	
17. NAME OF REFERRING PROVIDER OR OTHER SOURCE [REDACTED]		18. DATE PATIENT UNABLE TO WORK IN CURRENT OCCUPATION FROM MM DD YY TO MM DD YY	
19. RESERVED FOR LOCAL USE		19. HOSPITALIZATION DATES RELATED TO CURRENT SERVICES FROM MM DD YY TO MM DD YY	
20. OUTSIDE LAB? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		21. MEDICAID RESUBMISSION CODE [REDACTED] ORIGINAL REF. NO. [REDACTED]	
22. PRIOR AUTHORIZATION NUMBER [REDACTED]		23. DATE OF SERVICE From MM DD YY To MM DD YY	
24. A. DATE OF SERVICE From MM DD YY To MM DD YY		24. B. PLACE OF SERVICE [REDACTED]	
24. C. PROCEDURES, SERVICES, OR SUPPLIES (Specify Unusual Circumstances) OPTICCS [REDACTED]		24. D. DIAGNOSIS POINTER [REDACTED]	
24. E. CHARGES \$ 4408 00		24. F. DAYS OF LIFE 1	
24. G. NPI NPI [REDACTED]		24. H. ID. QUAL. NPI [REDACTED]	
24. I. RENDERING PROVIDER ID. # [REDACTED]		24. J. [REDACTED]	
25. FEDERAL TAX ID. NUMBER 27-4620480		26. PATIENT'S ACCOUNT NO. [REDACTED]	
27. ACCEPT ASSIGNMENT? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		28. TOTAL CHARGE \$ 257117 00	
29. SIGNATURE OF PHYSICIAN OR SUPPLIER INCLUDING DISCIPLES OR CREDENTIALS (I certify that the statements on the reverse apply to this bill and are made a part thereof.) JOHN CIFELLI, MD SIGNED [REDACTED] DATE 04 08 2011		30. AMOUNT PAID \$ 0 00	
31. SERVICE FACILITY LOCATION INFORMATION ST MARY'S HOSPITAL 350 BOULEVARD PASSAIC, NJ 07065		32. BILLING PROVIDER INFO & PH # 973 777 9278 NEUROLOGICAL SURGERY ASSOCIATES, PA 1054 CLIFTON AVENUE CLIFTON NJ 07013	
33. BALANCE DUE \$ 257117 00		34. [REDACTED]	

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1500

HEALTH INSURANCE CLAIM FORM

APPROVED BY NATIONAL UNIFORM CLAIM COMMITTEE 06/01

AETNA USHC
PO BOX 981108
EL PASO, TX 79998

<input type="checkbox"/> MEDICARE <input type="checkbox"/> MEDICAID <input type="checkbox"/> TRICARE <input type="checkbox"/> CHAMPVA <input type="checkbox"/> GROUP HEALTH PLAN <input type="checkbox"/> OTHER <input checked="" type="checkbox"/> AETNA USHC (Medicare #) (Medicaid #) (Tricare #) (Member ID#) (SSN or ID) (SSN) (SSN)										1a. INSURED'S LD. NUMBER (For Program in Item 1)																																																																																									
2. PATIENT'S NAME (Last Name, First Name, Middle Initial) O. [REDACTED] D. [REDACTED]										3. PATIENT'S BIRTH DATE [REDACTED] M. [REDACTED] F. [REDACTED]										4. INSURED'S NAME (Last Name, First Name, Middle Initial) O. [REDACTED] D. [REDACTED]																																																																															
5. PATIENT'S ADDRESS (No., Street) [REDACTED]										6. PATIENT RELATIONSHIP TO INSURED Self <input checked="" type="checkbox"/> Spouse <input type="checkbox"/> Child <input type="checkbox"/> Other <input type="checkbox"/>										7. INSURED'S ADDRESS (No., Street) [REDACTED]																																																																															
CITY [REDACTED]										STATE [REDACTED]										CITY [REDACTED]										STATE [REDACTED]																																																																					
ZIP CODE [REDACTED]										TELEPHONE (Include Area Code) [REDACTED]										ZIP CODE [REDACTED]										TELEPHONE (Include Area Code) [REDACTED]																																																																					
8. OTHER INSURED'S NAME (Last Name, First Name, Middle Initial) O. [REDACTED] D. [REDACTED]										9. OTHER INSURED'S POLICY OR GROUP NUMBER [REDACTED]										10. IS PATIENT'S CONDITION RELATED TO: a. EMPLOYMENT? (Current or Previous) <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO										11. INSURED'S POLICY GROUP OR PECA NUMBER [REDACTED]																																																																					
12. PATIENT'S OR AUTHORIZED PERSON'S SIGNATURE: I authorize the release of any medical or other information necessary to process this claim, I also request payment of government benefits either to myself or to the party who accepts assignment below. SIGNED: [REDACTED] DATE: 04 08 2011										13. INSURED'S OR AUTHORIZED PERSON'S SIGNATURE: I authorize payment of medical benefits to the undersigned physician or supplier services described below. SIGNED: [REDACTED] DATE: 04 08 2011										14. DATE OF CURRENT ILLNESS (First symptoms) OR INJURY (Accident) OR PREGNANCY (LMP) MM DD YY [REDACTED]										15. IF PATIENT HAS HAD SAME OR SIMILAR ILLNESS, GIVE FIRST DATE MM DD YY [REDACTED]										16. DATES PATIENT UNABLE TO WORK IN CURRENT OCCUPATION FROM MM DD YY TO MM DD YY [REDACTED]																																																											
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21. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY (Relate items 1, 2, 3 or 4 to Item 24E by Line) 1. 722 10 LUMBAR DISC DISPLACE 2. 724 2 LUMBAGO 3. 724 4 LUMBOSACRAL NEURITIS 4. 724 02 SPINAL STENOSIS LUMB										22. MEDICARE REIMBURSEMENT CODE [REDACTED]										23. PRIOR AUTHORIZATION NUMBER [REDACTED]																																																																															
24. A. DATE(S) OF SERVICE From MM DD YY To MM DD YY 04 08 11 04 08 11										B. PLACE OF SERVICE [REDACTED]										C. EMO [REDACTED]										D. PROCEDURES, SERVICES, OR SUPPLIES (Specify Unusual Circumstances) CPT/HCPCS MODIFIER 63047 59 AS 1234										E. DIAGNOSIS (ICD-9) 1234										F. CHARGES 36423 00										G. DATE OF INTR 1										H. PAY PER NPI										I. ID. QUAL. NPI										J. RENDERING PROVIDER ID. # NPI									
25. FEDERAL TAX ID. NUMBER 27-4620480										26. PATIENT'S ACCOUNT NO. [REDACTED]										27. ACCEPT ASSIGNMENT? <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO										28. TOTAL CHARGE \$ 250030.00										29. AMOUNT PAID \$ 0.00										30. BALANCE DUE \$ 250030.00																																																	
31. SIGNATURE OF PHYSICIAN OR SUPPLIER INCLUDING DEGREE OR CREDENTIALS (I certify that the statements on this review apply to this bill and are made a part thereof.) SARAH BODIE, PA-C										32. SERVICE FACILITY LOCATION INFORMATION ST MARY'S HOSPITAL 350 BOULEVARD PASSAIC, NJ 07055										33. BILLING PROVIDER INFO & PH # 973 777 9279 NEUROLOGICAL SURGERY ASSOCIATES, PA 1054 CLIFTON AVENUE CLIFTON NJ 07013																																																																															

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APPROVED OMB-0938-0899 FORM CMS-1500 (01

CIF000008

1500

HEALTH INSURANCE CLAIM FORM

APPROVED BY NATIONAL UNIFORM CLAIM COMMITTEE 08/05

AETNA USHC
PO BOX 981108
EL PASO, TX 79998

<input type="checkbox"/> PICA 1. MEDICARE <input type="checkbox"/> MEDICAID <input type="checkbox"/> TRICARE <input type="checkbox"/> CHAMPVA <input type="checkbox"/> GROUP HEALTH PLAN <input type="checkbox"/> FECA <input checked="" type="checkbox"/> OTHER <input checked="" type="checkbox"/> (NO)		1a. INSURED'S I.D. NUMBER (For Program in Item 1)	
2. PATIENT'S NAME (Last Name, First Name, Middle Initial) O. [REDACTED] D. [REDACTED]		3. PATIENT'S BIRTH DATE 01 08 1968 M <input type="checkbox"/> F <input checked="" type="checkbox"/>	
5. PATIENT'S ADDRESS (No., Street) [REDACTED]		6. PATIENT RELATIONSHIP TO INSURED Self <input checked="" type="checkbox"/> Spouse <input type="checkbox"/> Child <input type="checkbox"/> Other <input type="checkbox"/>	
CITY [REDACTED] STATE [REDACTED]		7. INSURED'S ADDRESS (No., Street) [REDACTED]	
ZIP CODE [REDACTED] TELEPHONE (Include Area Code) [REDACTED]		8. PATIENT STATUS Single <input type="checkbox"/> Married <input type="checkbox"/> Other <input checked="" type="checkbox"/>	
9. OTHER INSURED'S NAME (Last Name, First Name, Middle Initial) O. [REDACTED] D. [REDACTED]		10. IS PATIENT'S CONDITION RELATED TO: a. EMPLOYMENT? (Current or Previous) <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO	
b. OTHER INSURED'S POLICY OR GROUP NUMBER [REDACTED]		c. AUTO ACCIDENT? <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO	
d. OTHER INSURED'S DATE OF BIRTH [REDACTED] M <input type="checkbox"/> F <input checked="" type="checkbox"/>		e. OTHER ACCIDENT? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO	
e. EMPLOYER'S NAME OR SCHOOL NAME [REDACTED]		10a. RESERVED FOR LOCAL USE	
f. INSURANCE PLAN NAME OR PROGRAM NAME PROCURA		11. INSURED'S POLICY GROUP OR FECA NUMBER [REDACTED]	
g. INSURANCE PLAN NAME OR PROGRAM NAME AETNA USHC		12. IS THERE ANOTHER HEALTH BENEFIT PLAN? <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO	
13. PATIENT'S OR AUTHORIZED PERSON'S SIGNATURE I authorize the release of any medical or other information necessary to process this claim. I also request payment of government benefits either to myself or to the party who accepts assignment below. SIGNED Signature on File DATE 04 08 2011		14. INSURED'S OR AUTHORIZED PERSON'S SIGNATURE I authorize payment of medical benefits to the undersigned physician or supplier if services described below. SIGNED Signature on File	
14. DATE OF CURRENT ILLNESS (First symptoms) OR INJURY (Accident) OR PREGNANCY (LMP) MM DD YY 04 08 11		15. IF PATIENT HAS HAD SAME OR SIMILAR ILLNESS, GIVE FIRST DATE MM DD YY	
17. NAME OF REFERRING PROVIDER OR OTHER SOURCE [REDACTED]		18. DATES PATIENT UNABLE TO WORK IN CURRENT OCCUPATION FROM MM DD YY TO MM DD YY	
19. RESERVED FOR LOCAL USE		19. HOSPITALIZATION DATES RELATED TO CURRENT SERVICES FROM MM DD YY TO MM DD YY	
21. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY (Indicate Name 1, 2, 3 or 4 to Item 24E by Line) 1. 722 10 LUMBAR DISC DISPLACE 2. 724 4 LUMBOSACRAL NEURITIS 3. 724 2 LUMBAGO 4. 724 02 SPINAL STENOSIS LUMB		20. OUTSIDE LAB? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO \$ CHARGES	
22. MEDICAID RE submission CODE ORIGINAL REF. NO.		23. PRIOR AUTHORIZATION NUMBER	
24. A. DATE(S) OF SERVICE From MM DD YY To MM DD YY 04 08 11 04 08 11		B. PLACE OF SERVICE INP	
C. D. PROCEDURES, SERVICES, OR SUPPLIES (Explain Unusual Circumstances) CPT/HCPCS NOCIPER		E. DIAGNOSIS POINTER	
1 04 08 11 04 08 11 21 02 22851 AS 1234 11380 00 1 NP1		2 04 08 11 04 08 11 21 02 22840 AS 1234 18175 00 1 NP1	
3 04 08 11 04 08 11 21 02 89800 AS 1234 4000 00 1 NP1		4 04 08 11 04 08 11 21 02 22899 59 AS 1234 2000 00 1 NP1	
5 04 08 11 04 08 11 21 02 22899 59 AS 1234 2000 00 1 NP1		6 04 08 11 04 08 11 21 02 22812 AS 1234 3822 00 1 NP1	
25. FEDERAL TAX I.D. NUMBER 27-4820490		26. PATIENT'S ACCOUNT NO. [REDACTED]	
27. SIGNATURE OF PHYSICIAN OR SUPPLIER INCLUDING DEGREE OR CREDENTIALS (I certify that the statements on the reverse apply to this bill and are made a part thereof.) SARAH BODIE, PA-C		28. SERVICE FACILITY LOCATION INFORMATION ST MARY'S HOSPITAL 350 BOULEVARD PASSAIC, NJ 07055	
29. BILLING PROVIDER INFO & PH # 973 777 9270 NEUROLOGICAL SURGERY ASSOCIATES, PA 1054 CLIFTON AVENUE CLIFTON NJ 07013		30. TOTAL CHARGE \$ 250030 00	
31. AMOUNT PAID \$ 0 00		32. BALANCE DUE \$ 250030 00	

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APPROVED OMB-0838-0999 FORM CMS-1500 (08

CIF000009

1500

HEALTH INSURANCE CLAIM FORM

APPROVED BY NATIONAL UNIFORM CLAIM COMMITTEE 08/05

AETNA USHC
PO BOX 681106
EL PASO, TX 79998

<input type="checkbox"/> PICA		1. MEDICARE <input type="checkbox"/> MEDICAID <input type="checkbox"/> TRICARE <input type="checkbox"/> CHAMPVA <input type="checkbox"/> GROUP HEALTH PLAN <input type="checkbox"/> FECA <input type="checkbox"/> OTHER <input checked="" type="checkbox"/> (NO)		1a. INSURED'S ID. NUMBER (For Program in Item 1)	
2. PATIENT'S NAME (Last Name, First Name, Middle Initial) O. [REDACTED] D. [REDACTED]		3. PATIENT'S BIRTH DATE [REDACTED] M. [REDACTED] F. [REDACTED]		4. INSURED'S NAME (Last Name, First Name, Middle Initial) O. [REDACTED] D. [REDACTED]	
5. PATIENT'S ADDRESS (No., Street) [REDACTED]		6. PATIENT RELATIONSHIP TO INSURED Self <input checked="" type="checkbox"/> Spouse <input type="checkbox"/> Child <input type="checkbox"/> Other <input type="checkbox"/>		7. INSURED'S ADDRESS (No., Street) [REDACTED]	
CITY [REDACTED] STATE [REDACTED]		8. PATIENT STATUS Single <input type="checkbox"/> Married <input type="checkbox"/> Other <input checked="" type="checkbox"/>		CITY [REDACTED] STATE [REDACTED]	
ZIP CODE [REDACTED] TELEPHONE (Include Area Code) [REDACTED]		9. EMPLOYMENT (Current or Previous) Employed <input type="checkbox"/> Full-Time Student <input type="checkbox"/> Part-Time Student <input type="checkbox"/>		10. INSURED'S POLICY GROUP OR FECA NUMBER [REDACTED]	
10. OTHER INSURED'S NAME (Last Name, First Name, Middle Initial) O. [REDACTED] D. [REDACTED]		10. IS PATIENT'S CONDITION RELATED TO: a. EMPLOYMENT? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO b. AUTO ACCIDENT? <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO c. OTHER ACCIDENT? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO		11. INSURED'S DATE OF BIRTH [REDACTED] M. [REDACTED] F. <input checked="" type="checkbox"/>	
a. OTHER INSURED'S POLICY OR GROUP NUMBER [REDACTED]		b. AUTO ACCIDENT? <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO		b. EMPLOYER'S NAME OR SCHOOL NAME [REDACTED]	
b. OTHER INSURED'S DATE OF BIRTH [REDACTED] M. [REDACTED] F. <input checked="" type="checkbox"/>		c. OTHER ACCIDENT? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO		c. INSURANCE PLAN NAME OR PROGRAM NAME AETNA USHC	
c. EMPLOYER'S NAME OR SCHOOL NAME [REDACTED]		10d. RESERVED FOR LOCAL USE		d. IS THERE ANOTHER HEALTH BENEFIT PLAN? <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO If yes, return to and complete Item 11 a-d.	
d. INSURANCE PLAN NAME OR PROGRAM NAME PROCURA		12. PATIENT'S OR AUTHORIZED PERSON'S SIGNATURE (I authorize the release of any medical or other information necessary to process this claim. I also request payment of government benefits either to myself or to the party who accepts assignment below.) SIGNED [REDACTED] DATE 04 08 2011		13. INSURED'S OR AUTHORIZED PERSON'S SIGNATURE (I authorize payment of medical benefits to the undersigned physician or supplier if services described below.) SIGNED [REDACTED] DATE 04 08 2011	
14. DATE OF CURRENT ILLNESS (First symptom) OR INJURY (Accident) OR PREGNANCY (Last) MM DD YY [REDACTED]		15. IF PATIENT HAS HAD SAME OR SIMILAR ILLNESS, GIVE FIRST DATE MM DD YY [REDACTED]		16. DATES PATIENT UNABLE TO WORK IN CURRENT OCCUPATION FROM MM DD YY TO MM DD YY [REDACTED]	
17. NAME OF REFERRING PROVIDER OR OTHER SOURCE [REDACTED]		17b. NPI [REDACTED]		18. HOSPITALIZATION DATES RELATED TO CURRENT SERVICES FROM MM DD YY TO MM DD YY [REDACTED]	
19. RESERVED FOR LOCAL USE		20. OUTSIDE LAST \$ CHARGES <input type="checkbox"/> YES <input type="checkbox"/> NO		21. MEDICARE RESUBMISSION CODE ORIGINAL REF. NO.	
21. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY (Relate Items 1, 2, 3 or 4 to Item 24b by Line) 1. 722 10 LUMBAR DISC DISPLACE 2. 724 2 LUMBAGO 3. 724 02 SPINAL STENOSIS LUMB		22. PRIOR AUTHORIZATION NUMBER		23. BILLING PROVIDER INFO & PH # 973 771 9278	
24. A. DATE(s) OF SERVICE From MM DD YY To MM DD YY 04 08 1 04 08 1 21 02 B. PLACE OF SERVICE EMO 21 02 C. PROCEDURE, SERVICE, OR SUPPLIES (Specify Unusual Circumstances) 20937 AS D. DIAGNOSIS POINTER 1234 E. CHARGES 2502 00 F. DAYS OF UNIT 1 G. ID. CUM. NPI H. BILLING PROVIDER ID. # [REDACTED]		25. FEDERAL TAX ID. NUMBER SSN EIN 27-4620460 [REDACTED]		26. PATIENT'S ACCOUNT NO. [REDACTED]	
27. ACCEPT ASSIGNMENT? <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO		28. TOTAL CHARGE \$ 250030.00		29. AMOUNT PAID \$ 0.00	
30. BALANCE D \$ 250030		31. SIGNATURE OF PHYSICIAN OR SUPPLIER INCLUDING DEGREE OR CREDENTIALS (I certify that the statement on the reverse apply to this bill and are made a part thereof.) SARAH BODIE, PA-C SIGNED [REDACTED] DATE 04 08 2011		32. SERVICE FACILITY LOCATION INFORMATION ST MARY'S HOSPITAL 350 BOULEVARD PASSAIC, NJ 07055 SIGNED [REDACTED] DATE 04 08 2011	
33. BILLING PROVIDER INFO & PH # 973 771 9278 NEUROLOGICAL SURGERY ASSOCIATES, PA 1054 CLIFTON AVENUE CLIFTON NJ 07013 SIGNED [REDACTED] DATE 04 08 2011		34. BILLING PROVIDER INFO & PH # [REDACTED]		35. BILLING PROVIDER INFO & PH # [REDACTED]	

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